DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/26/11

PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED REGIONAL MEDICAL CENTER NURSING HOME	1001 MCARTHUR DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the hazardous areas. The findings include: Observation of the mechanical room by room 611 and the boiler room on 5/9/11 at 10:30 AM, revealed penetrations in the walls and in the ceilings. This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11.	K 029	K29 On 5/13/11, the Maintenance Director repaired the penetrations in the mechanical room by room 611. The Maintenance Director will have the penetrations repaired in the boiler room by 6/3/11. All residents have the potential to be affected in the event of a fire. The Maintenance Director or his designee will be responsible for checking all areas of the facility to ensure all areas are properly maintained and free of any penetrations in the walls or ceilings. The Maintenance Director or his designee will monitor this by random observation throughout the facility five times per week times four week and then weekly to ensure compliance. The Maintenance Director will report audit findings to the Administrator monthly. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and is composed of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Maintenance Director and others as indicated.	6/3/11
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050	K50 On 5/25/11, the Maintenance Director will also conduct an in-service for all nursing home staff on the policy and procedures to be followed in the event of a fire. The	6/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Beth Hopkins — TITLE: Administrator — (X6) DATE: 5/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed the fire drill. The findings include: Observation during the fire drill on 5/9/11 at 10:32 AM, revealed the staff did not announce the code red, the location of the fire, and failed to activate the fire alarm system. This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11.	K 050	Maintenance Director will be responsible for conducting fire drills weekly times four weeks and then at least monthly. All residents have the potential to be affected in the event of a fire. The Maintenance Director or his designee will be responsible for ensuring that all employees are properly trained. The results of the fire drills will be submitted to the Administrator monthly by the Maintenance Director. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and is composed of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Maintenance Director and others as indicated.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoke detectors. The findings include: Observation of the corridor by room 506 on 5/9/11 at 10:05 AM, revealed the smoke detector	K 054	K54 On 5/19/11, The Maintenance Director moved the smoke detector in the corridor by room 506 so that it is more than 3 feet from the air diffuser. All residents have the potential to be affected in the event of a fire. The Maintenance Director or his designee will be responsible for ensuring that all smoke detectors are greater than 3 feet from any air diffuser. This will be done by making walking rounds throughout the facility with direct observation of all smoke detectors to ensure compliance by the	6/3/11

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K 054	Continued From page 2 was installed within 3 feet of the air diffuser. This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11.	K 054	Maintenance Director. This audit will be completed monthly and results submitted to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and is composed of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director, Maintenance Director and others as indicated.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system. The findings include: Observation of the supply room by room 506 on 5/9/11, revealed supplies stored within 18 inches of the sprinkler. This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical system.	K 147		

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system. The findings include: Observation of the supply room by room 506 on 5/9/11, revealed supplies stored within 18 inches of the sprinkler. This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 5/9/11.	K 062	K62 The supplies stored with-in the 18-inch rule of the sprinkler heads in the storage room by room 506 were removed 5/19/11 All residents have the potential to be affected in the event of a fire due to sprinklers not being able to function properly if supplies are stored above the 18-inch rule. All employees will be in-serviced 5/25/11 regarding the 18-inch rule for the sprinkler system. The Administrator or her designee will monitor the corrective action to ensure effectiveness of this action by performing random walking rounds throughout the facility five times per week times 4 weeks to monitor the 18-inch rule. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	6/3/11
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical system.	K 147		

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K 147	Continued From page 3 The findings include: Observation of the kitchen dry storage room on 5/9/11 at 11:00 AM, revealed the electrical panel was blocked with equipment. This finding was acknowledged by the Administrator and verified by the Director of maintenance at the exit conference on 5/9/11.	K 147	K147 The equipment blocking the electrical panels in the kitchen dry storage room was removed on 5/9/11 by maintenance personnel. All residents have the potential to be affected in the event of a fire or electrical outage. Maintenance employees will be in-serviced on 5/25/11 regarding properly maintaining the electrical system. Administrator or their designee will monitor the corrective action to ensure the effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to ensure no electrical panels are blocked. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of this monitoring will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant DON, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	6/3/11